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JOHN REDDY

PASSPORT TO HEALTH

Provider Guide

MONTANA HEALTH CHOICES

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About Montana Health Choices

Montana Health Choices is an enrollment and educational service for Medicaid clients and providers, and is the administrator of the PASSPORT TO HEALTH program.

Montana Health Choices publishes this *Provider Guide*, a *Client Handbook*, and quarterly provider and client newsletters, as well as other educational and informational materials.

Our client HelpLine assists clients with enrolling in Medicaid managed care (PASSPORT TO HEALTH), educates clients about Medicaid and managed care, and answers clients' questions.

The Provider HelpLine answers providers' questions about Medicaid services and the PASSPORT program, and addresses provider concerns.

Montana Health Choices is operated by MAXIMUS, under contract with the Department of Public Health and Human Services.

Call the Provider HelpLine at 1-800-480-6823, Monday through Friday, 8 a.m. to 5 p.m., to ask about educational materials available for providers.

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PASSPORT TO HEALTH

What is PASSPORT TO HEALTH?

PASSPORT TO HEALTH is one of Montana's managed care programs for Medicaid clients.

In PASSPORT, clients choose a primary care provider who acts as a "gatekeeper" for most medical services.

PASSPORT TO HEALTH is designed to build a strong relationship between the patient and his or her primary care provider.

The PASSPORT TO HEALTH managed care program:

1. assures adequate access to primary care,
2. improves the continuity of care,
3. decreases the inappropriate use of medical services, and
4. reduces health care costs.

What managed care model is PASSPORT based on?

PASSPORT is based on the primary care case management model of coordinated care. PASSPORT primary care providers manage the care of Medicaid clients, and may refer them to any Medicaid provider in the community.

PASSPORT providers act as "gatekeepers" for other services. PASSPORT providers bill Medicaid for all services provided to their patients and receive the standard Medicaid reimbursement. For PASSPORT providers, there is no financial risk associated with caring for Medicaid clients.

PASSPORT providers receive an additional $3 per enrollee, per month, case management fee above and beyond the reimbursement for services as an incentive to participate.

For more information about PASSPORT TO HEALTH, *look in Section* XI *of the yellow* Medicaid *manual* (Montana Medicaid Provider Handbook).

What are some advantages of primary care case management?

Primary care case management strengthens the physician-patient relationship and enhances continuity of care.

What distinguishes a PASSPORT provider from another Medicaid provider?

A PASSPORT primary care provider manages a client's health care by providing most medical services, referring the client to other providers for services when necessary, and keeping all of the client's medical records.

Medicaid Services

Are all Medicaid clients entitled to the same services?

No. Some clients may be eligible for FULL Medicaid, and some may be eligible for BASIC Medicaid.

FULL Medicaid means that the state pays for all Medicaid-covered health services.

BASIC Medicaid means that some Medicaid services are not paid for, except in emergencies or where a job requires the services.

Who may be eligible for FULL Medicaid?

These individuals may be eligible for FULL Medicaid:

1. pregnant women,
2. children under the age of 21, and
3. adults who are blind, aged, or disabled and on SSI.

Who may be eligible for BASIC Medicaid?

The following individuals may be eligible for BASIC Medicaid: Adults in FAIM (Families Achieving Independence in Montana) who are preparing to go back to work, and who need health insurance and other services, such as food stamps. (Adults who are eligible for FULL Medicaid are not in FAIM.)

Which services are Medicaid clients entitled to?

The nine-page chart that follows lists services covered by Medicaid. Note that some services require the authorization of a PASSPORT provider. FULL Medicaid covers all services in the chart.

Service Covered by FULL Medicaid	Covered under BASIC Medicaid	Need PASSPORT Authorization	Copayment‡
Ambulance (no age limit) Emergency ground and air transport. Emergency and non-emergency services require authorization from the Medicaid Transportation Center. For non-emergency transportation, services must be ordered by a physician, client must be stretcher-bound, and trip must be approved by Medicaid before transport.	Yes	No	No
Ambulatory Surgical Center (no age limit) Surgeries at outpatient surgery centers.	Yes	Yes	$1 per service
County Public Health Clinic (no age limit) All Medicaid-covered services are covered at publicly funded clinics that provide regular, non-emergency care.	Yes	Yes*	$1 per service
**except family planning, pregnancy care, immunizations, or mental health services*			
Dental (no age limit) Including denture services provided by denturists, and most dental care such as exams and cleaning. For other services, including dentures, the dentist must get authorization from Medicaid. Call the Medicaid program officer at DPHHS (406-444-4540). (Some services require prior authorization or have limits.)	No*	No	$2 per service for dentists $2 per service for oral surgeons $2 per service for denturists
**except for draining an abscess or emergency extractions*			

Service Covered by FULL Medicaid	Covered under BASIC Medicaid	Need PASSPORT Authorization	Copayment‡
Dialysis (no age limit) Includes outpatient dialysis, training for self-dialysis, and home dialysis. Home dialysis includes trained nurses to assist only if there is not a family member to assist. Client must have a terminal kidney disease.	Yes	No	$1 per service in a hospital $2 per service not in a hospital No copayment for a home attendant
Drugs, prescription (no age limit) Some drugs have limited access and some require prior authorization. To request prior authorization, or for inquiries about limited access drugs, call 1-800-395-7961.	Yes	No	$2 per brand name $1 per generic
Durable Medical Equipment (no age limit) Includes most medical supplies, artificial limbs and devices. Items costing $1000 or more, air-fluid beds, communication devices, hospital beds and wheelchairs require authorization from Medicaid before they are purchased.	No*	No	.50 per item

**except diabetic supplies, oxygen, some prosthetics, ostomy and incontinence supplies*

‡Pregnant women and children under 21 do not make copayments.

Service Covered by FULL Medicaid	Covered under BASIC Medicaid	Need PASSPORT Authorization	Copayment‡
Emergency Room (no age limit) Client could be held responsible for an emergency room bill if used in non-emergent or life-threatening cases. An emergency means the symptoms of the medical condition seem so severe that a prudent layperson (a person with average knowledge of health and medicine) would expect that there might be danger to the health of the individual unless the symptoms were treated immediately.	Yes	Yes, for services that are not emergency services	No, for emergency services All other services have a copayment
Eye Exams (no age limit) One eye exam every 24 months for adults (unless vision changes significantly); one eye exam every 12 months for age 20 and under, unless vision changes significantly or for treatment of eye disease.	No*	No	$2 per service
** except for the following conditions designated by ICD-9 diagnosis codes:* 360.0-366.9, 368.1-368.2, 368.4-368.47, 370-372.39, 372.6-374.23, 374.5-377.9, 379-379.19, 379.23, 379.26, V58.69, 379.29, 379.32-379.39, 379.54, 379.8-379.9			
Eyeglasses (no age limit) One pair of eyeglasses every 24 months. One pair every 12 months for age 20 and under.	No	No	$1 per dispensing fee

Service Covered by FULL Medicaid	Covered under BASIC Medicaid	Need PASSPORT Authorization	Copayment‡
Family Planning (no age limit)	Yes	o	

Clients are given freedom to self-refer for family planning services.

Family planning services for purposes of self-referral are defined as:

1. reproductive health exams comprised of taking history and conducting a physical assessment when such an exam is necessary to obtain birth control supplies or to determine the most appropriate birth control method or supply;

2. patient counseling and education for the following: contraception, sexuality, infertility, pregnancy, preconceptual care, pregnancy options, sexually transmitted disease, HIV/AIDS, sterilizations, nutrition to maximize reproductive health, the need for rubella and hepatitis B immunizations, and other topics related to the patient's reproductive and general health;

3. lab tests to detect the presence of conditions affecting reproductive health, such as those involving the thyroid, cholesterol/triglycerides, prolactin, pregnancy tests, and the diagnosis of infertility;

4. sterilizations for mentally competent individuals 21 years and older if a consent form is signed by the person at least 30 days, but not more than 180 days, in advance;

5. screening, testing and treatment of, and pre- and post-test counseling for, sexually transmitted diseases including HIV;

6. family planning supplies; and

7. rubella and hepatitis B immunizations for individuals eighteen years and under who fall under the definition of high risk group.

Federally Qualified Health Center (FQHC), and Rural Health Clinic (RHC)	Yes	Yes*	$2 per service

**unless the FQHC or RHC is the client's PASSPORT provider, except for family planning, pregnancy-related services, immunizations, and mental health*

Hearing Aids (no age limit) Requires prior authorization from Medicaid. Call 406-444-4540.	No	No	$1 per service

‡Pregnant women and children under 21 do not make copayments.

Service Covered by FULL Medicaid	Covered under BASIC Medicaid	Need PASSPORT Authorization	Copayment‡
Hearing Exams (no age limit)	No	No	$1 per service
Home and Community Based Waiver Must be assessed and determined eligible by the community-based case management team.	Yes	No	No
Home Health Care Services include some care in the home from a nurse, home health aide, physical therapist, occupational therapist or speech therapist. Some medical supplies are also covered. Services must be ordered by a physician and the patient must be home bound. If a person receives personal care attendant services they are not eligible for home health aide visits.	Yes	Yes	$2 per service .50 per item for supplies & equipment
Home Care/Personal Care Attendant Services Services include assistance with activities for daily living. Household duties must be directly related to medical needs and be part of the medical care plan. Services must be ordered by a physician, supervised by a nurse when necessary, and provided by a personal care attendant employed by a personal care services provider.	No	No	No

Service Covered by FULL Medicaid	Covered under BASIC Medicaid	Need PASSPORT Authorization	Copayment‡
Home Infusion Therapy (no age limit) Services include drug treatments given intravenously in the home setting by a licensed person.	Yes	No	.50 per service
Hospice (no age limit) All care related to the terminal condition of a person is managed by the hospice. Grief counseling is also available to the person's family. A physician must certify that the person is expected to die within 6 months.	Yes	No	No
Hospital, Inpatient (no age limit) Services include those offered in a hospital setting and limited to medically necessary stays, including drug and alcohol detoxification.	Yes	Yes*	$100 per stay
Hospital, Outpatient (no age limit) Services include emergency room and outpatient services such as physical therapy, dialysis, lab, and diabetes education. Medicaid does not cover cardiac rehabilitation, pulmonary rehabilitation, education or exercise programs.	Yes	Yes	$1 per service

**For out-of-state services, prior authorization is required from the Mountain Pacific Quality Health Foundation.*

‡Pregnant women and children under 21 do not make copayments.

Service Covered by FULL Medicaid	Covered under BASIC Medicaid	Need PASSPORT Authorization	Copayment‡
Hospital, Swing Beds Includes nursing home services.	Yes	No	No
Mental Health Mental health services provided by physicians. Includes all mental health providers and includes case management.	Yes	No	Yes, some services
Physician (no age limit) Most physician services are covered, including anesthesiology.	Yes	Yes*	$2 per service
**except for family planning, pregnancy-related services, immunizations, vision, dental care, and certain other services*			
Podiatry (no age limit) Services include cutting or removing corns or calluses, trimming nails, applying skin creams, measuring and fitting foot and ankle devices and lab services and supplies. Orthopedic shoes are covered if you are under 21 or there is a brace or an orthopedic device attached to the shoe.	Yes	No	$2 per service

Service Covered by FULL Medicaid	Covered under BASIC Medicaid	Need PASSPORT Authorization	Copayment‡
Targeted Case Management Medicaid may cover the cost of planning for medical, social, educational, nutritional and other Medicaid-covered services. The following groups may obtain this assistance: 1. high-risk pregnant women and their babies through 1 year of life; 2. people 18 and up with severe and disabling mental illness; 3. people 16 and up with developmental disabilities; 4. severely emotionally disturbed children; 5. children at risk for abuse and neglect; and 6. children with special health needs.	Yes	No	No
Therapy (no age limit) **Occupational and Physical Therapy:** Therapy must be restorative. If the therapist does not work for a hospital and the person is 21 years or older, they are limited to 70 hours of therapy per fiscal year (July 1 to June 30). An additional 30 hours may be authorized by Medicaid if medically necessary.	Yes	Yes*	.50 per service
Speech Therapy: Speech therapy is limited to 70 units. Thirty additional units may be authorized. **required whether the provider is independent, hospital, or school-based*	Yes	Yes*	.50 per service
Transplants Individuals 20 years and under are covered for all medically necessary, non-experimental transplants. *(Transplants continued on next page.)*	Yes	Yes*	No

‡Pregnant women and children under 21 do not make copayments.

Service Covered by FULL Medicaid	Covered under BASIC Medicaid	Need PASSPORT Authorization	Copayment‡
Transplants (continued) Individuals 21 years and older are limited to kidney, cornea, and bone marrow transplants for certain conditions. *Requires prior authorization from the Mountain Pacific Quality Health Foundation.	Yes	Yes	$100 for hospitalization
Transportation (non-emergency) Services include: • wheelchair van, • commercial travel such as a bus or taxi, and • mileage and per diem (money to assist with gasoline, food and lodging if medical services are required away from home). Travel is covered only to get necessary Medicaid-covered services from the nearest provider and is limited to the least costly, but appropriate, means of transportation. The Medicaid Transportation Center (1-800-292-7114) will assist if non-emergency transportation is required. Calls must be made to the Medicaid Transportation Center before travel, or the client will be responsible for the bill.	Yes	No	$1 per trip for vehicles specially equipped to transport physically disabled people

‡Pregnant women and children under 21 do not make copayments.

Are there limits on copayments for Medicaid clients?

Yes. Medicaid clients pay no more than $200 in copayments per person, per fiscal year. Once the limit of $200 is reached, an asterisk (*) will appear on the client's Medicaid card.

Pregnant women make no copayments — even if the service is not related to pregnancy. If you prescribe medication for a pregnant woman, be sure to tell the pharmacist that the prescription does not require a copayment.

Children under age 21 and adults who are blind, aged, or disabled and on SSI also do not make copayments.

Copayments may not be charged for services provided in an emergency, family planning services, or blood lead testing services.

EPSDT: The Well Child Program

Medicaid providers are required to provide EPSDT services to every eligible child. Therefore, understanding the parameters and implementing EPSDT are important tasks for every provider.

What is EPSDT?

EPSDT (Early and Periodic Screening, Diagnosis and Treatment) is a program within Medicaid which provides comprehensive health care benefits for children up to age 21.

EPSDT was added to Medicaid in 1967, in recognition of the fact that regular checkups during the developmental years and early intervention, when health problems occur, can help children become healthy adults.

Medicaid clients know EPSDT as the Well Child Program.

Which states offer EPSDT services to Medicaid eligible children?

Every state that accepts Medicaid reimbursement for health services must offer the full complement of EPSDT services to eligible children. All 50 states have Medicaid programs and are required to offer EPSDT services.

Why has Montana Health Choices chosen to devote a chapter of this Guide to EPSDT?

The information in this chapter is important for Montana Medicaid providers.

Too few eligible children are receiving the EPSDT services to which they are entitled. In 1996, 22.9 million children throughout the nation were eligible for EPSDT. Only 37 percent of the children received a medical screen; 21 percent, a dental screen; 15 percent, a vision screen; and 13 percent, a hearing screen. State profiles of EPSDT participation vary considerably.

Furthermore, screening is not evenly distributed among age groups. Infants and young children are significantly more likely to receive health screens.

What are some common barriers to EPSDT?

The following are some barriers to EPSDT:

- Medicaid providers are not effectively informed about the broad spectrum of health services covered by EPSDT, and for which they can receive reimbursement.
- There is a shortage of providers participating in the Medicaid program.
- Medicaid clients are not always effectively informed about EPSDT and the benefits of the program.
- Some Medicaid clients may not value preventive health services.
- Transportation difficulties can make it difficult for children to see providers regularly.

Which children are entitled to EPSDT services?

All children receiving Medicaid benefits — including teenagers and young adults up to age 21 — are entitled to the full range of EPSDT services.

Who provides EPSDT services for children receiving Medicaid?

Most of the time a child's PASSPORT provider will provide EPSDT services. However, *any treatment identified as medically necessary may be provided by any health care provider, whether or not that provider is a* Medicaid *provider.*

What are the basic elements of EPSDT?

Well child checkups, including four types of screens, are basic to EPSDT.

The four screens required to be performed at distinct intervals are: medical, vision, hearing and dental.

How often should EPSDT screens be performed?

The intervals at which screens should be performed are determined by "periodicity schedules," which are based on the age of the child, and which meet the standards of pediatric and adolescent medical and dental practice.

At present, Medicaid clients are being told to bring children in for checkups at the following times, based on the child's age:

- ✓ before 1 month old
- ✓ at 2 months
- ✓ 4 months
- ✓ 6 months
- ✓ 9 months
- ✓ 12 months
- ✓ 15 months
- ✓ 18 months
- ✓ 24 months
- ✓ 3 years
- ✓ 4 years
- ✓ 6 years
- ✓ 8 years
- ✓ 10 years
- ✓ 12 years
- ✓ 14 years
- ✓ 16 years
- ✓ 18 years

How does a PASSPORT provider know when a child is due for an EPSDT screen?

The provider's monthly enrollee list, sent by MONTANA HEALTH CHOICES, includes information about which screen is due.

What is included in the medical EPSDT screen?

The medical EPSDT screen should include:

- a comprehensive health and developmental history, including assessment of both physical and mental health;
- a comprehensive, unclothed physical examination;
- appropriate immunizations;
- laboratory tests (including blood lead testing at 12 and 24 months and otherwise according to age and risk factors);
- health education, including anticipatory guidance.

What is anticipatory guidance?

Anticipatory guidance is thoughtful, professional advice and information given to both parent (or guardian) and the child about issues that can be expected to come up during the child's future. For example, guidance about how to handle alcohol, tobacco, and other drugs, problems which might occur with new drivers, and advice about how to avoid sexually transmitted diseases should be given to all emerging adolescents.

Are children entitled to services other than periodic screens?

Yes. EPSDT covers visits to a health care provider when needed outside of the periodicity schedule to determine whether a child has a condition that needs further care. Screens which are not part of the periodicity schedule are called "interperiodic screens."

What constitutes an interperiodic screen?

Any encounter with a health care professional acting within the scope of practice is considered to be an interperiodic screen, whether or not the provider is participating in the Medicaid program when services are provided.

Who can identify the need for an interperiodic screen?

Anyone involved in the child's life, including people outside the health care system (for example, a teacher or a parent) can determine the need for an interperiodic screen.

What happens if a health problem requiring treatment is identified during an EPSDT screen?

When corrective treatment is considered medically necessary, EPSDT requires Medicaid providers to arrange for corrective treatment, directly or through referral to appropriate agencies, organizations, or individuals.

Define the term "medically necessary."

"Medically necessary" means necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions.

What services are covered under EPSDT?

Covered services include all mandatory and optional services that any state can cover under Medicaid, whether or not such services are covered for adults.

PASSPORT providers are responsible for providing, or referring the child for any *medically necessary* services included in the following list.

- inpatient hospital services (other than services in an institution for mental disease)
- outpatient hospital services
- Rural Health Clinic services (including home visits for homebound individuals)
- Federally Qualified Health Center services
- laboratory and x-ray services
- EPSDT services (periodic checkups)
- family planning services and supplies
- physician services (in office, patient's home, hospital, nursing facility, or elsewhere)
- medical and surgical services furnished by a dentist
- medical care or any other type of remedial care
- home health care services (in place of residence)
- private duty nursing services (in the home, hospital, and/or skilled nursing facility)

- clinic services (including services outside of clinic for eligible homeless individuals)
- dental services
- physical therapy and related services (including occupational therapy and services for individuals with speech, hearing, and language disorders)
- prescribed drugs
- dentures
- prosthetic devices
- eyeglasses

- other diagnostic, screening, preventive, and rehabilitative services, including medical or remedial services recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level (in facility, home, or other setting)
- services in an intermediate care facility for the mentally retarded
- inpatient psychiatric hospital services for individuals under age 21
- services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle
- hospice care
- case management services
- TB-related services

- respiratory care services
- services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- community-supported living arrangement services (e.g. personal assistance, habilitation services, assistive technology), to the extent allowed and defined
- personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- primary care case management services
- any other medical care, and any other type of remedial care recognized under state law, specified by the secretary (includes transportation and personal care services in a client's home)

How are Medicaid clients informed about the EPSDT entitlement?

In the EPSDT legislation, Congress requires states to inform all Medicaid eligible persons under the age of 21 about EPSDT. States must use a combination of written and oral methods to inform individuals effectively about EPSDT, the value of preventive health care, and the availability on request of support services such as transportation and appointment scheduling assistance.

MONTANA HEALTH CHOICES publishes a *Client Handbook*, which is sent to all PASSPORT clients. It includes a chapter on the Well Child Program, a schedule for checkups, and information about the Medicaid Transportation Center.

The MONTANA HEALTH CHOICES HelpLine staff also makes outreach calls to all new Medicaid clients, during which they are educated about the Well Child program.

Each PASSPORT *provider's monthly enrollee list has a column titled "Well Child." When a child is due for an* EPSDT *screen, the screen interval is indicated in that column. For example, "four months."*

Becoming a PASSPORT Provider

Who can become a PASSPORT provider?

The following are eligible to become PASSPORT providers:

Physicians whose specialities are:

- family practice
- general practice
- internal medicine
- pediatrics
- obstetrics/gynecology

Note: Physicians with other specialities may also participate if they are the principal providers for patients with complex medical problems.

Mid-level Practitioners such as:

- Physician Assistants
- Certified Nurse Midwives
- Certified Nurse Practitioners
- Clinical Nurse Specialists

Clinics such as:

- Federally Qualified Health Centers
- Medicaid-designated Rural Health Clinics
- Indian Health Service Clinics
- Public Health Clinics

Note: If a clinic or private group practice wishes to enroll as a single entity, each physician and mid-level practitioner within the clinic or group practice who will participate must co-sign the PASSPORT provider agreement.

How can a provider enroll in PASSPORT?

To enroll in PASSPORT, call 1-800-480-6823 and ask for a PASSPORT provider agreement and information on becoming a PASSPORT provider.

Each PASSPORT provider must first be enrolled as a Montana Medicaid provider.

What is a PASSPORT provider required to do?

- Provide primary care, including preventive care, health maintenance, treatment of illness and injury, and coordination of PASSPORT services.
- Coordinate the client's access to medically necessary speciality care and other health services. Coordination includes referral, authorization, and follow-up.
- Authorize inpatient admissions.
- Provide continuous coverage for authorization of PASSPORT services, 24 hours a day, seven days a week.
- Provide or arrange for well child screens (EPSDT) and immunizations according to the periodicity schedule in the Medicaid Kids Count Provider Manual (available from Consultec).

- Maintain a unified patient medical record for each enrollee. This must include a record of all authorizations for other providers. Providers must transfer a copy of the client's medical record to a new primary care provider if requested in writing and authorized by the client.
- Review PASSPORT utilization rates (supplied by Medicaid) and analyze factors contributing to unusually high or low rates.
- Treat PASSPORT patients with respect. Discriminatory practices such as separate waiting rooms, separate appointment days, or preference to private pay patients are not allowed.

What does "24-hour coverage" mean?

Twenty-four-hour coverage means that PASSPORT enrollees must be able to reach either the PASSPORT provider or a designee who can provide medical advice or authorize treatment 24 hours a day, seven days a week, 365 days a year. *Medical office staff cannot authorize services or give referrals to other providers.*

Twenty-four hour coverage may be provided through call coverage by another provider, or the use of an answering machine with directions on how to reach a substitute medical professional to authorize services.

If an answering machine is used, the client should only be required to dial one other number before reaching a person who can offer medical advice or authorize treatment.

Can the emergency room be used as off-hours coverage?

Yes, provided the "E.R. Waiver" form has been signed by both the provider and the hospital emergency room. To get an E.R.Waiver form, call the PASSPORT Provider HelpLine at 1-800-480-6823.

24-hour coverage by PASSPORT *providers is monitored through random phone calls made after working hours.*

For information on how to become a Montana Medicaid provider, and for Medicaid provider agreements, call Consultec at 1-800-624-3958.

Are copayments required of PASSPORT clients?

Most services require copayments. Copayments will be deducted when reimbursement is made. See page 10 for the chart of covered services, including information about copayments.

For more information on Medicaid copayments, see the yellow Medicaid manual, Section V.

Note: *When a woman is pregnant, there are no copayments for any Medicaid health services provided to her — even if the service is not related to her pregnancy. If you prescribe medication for a pregnant woman, be sure to tell the pharmacist that the prescription does not require a copayment.*

Are there caseload limits for PASSPORT providers?

PASSPORT providers may serve as few as one Medicaid client or as many as 1,000.

Group practices and clinics may set a limit equal to 1,000 for each full-time equivalent provider.

Can PASSPORT providers recruit Medicaid clients?

Yes. PASSPORT providers may encourage Medicaid clients to enroll with them under the PASSPORT program.

Call Montana Health Choices at 1-800-480-6823 for additional information or to request enrollment forms, Client Handbooks and brochures.

Referral and Authorization

When should PASSPORT providers refer Medicaid clients for services?

PASSPORT providers should refer Medicaid clients for medically necessary services that they cannot provide. If the service requires authorization, the PASSPORT provider should supply it. PASSPORT *providers are responsible for ensuring that clients under age 21 obtain* EPSDT *screens and immunization services, whether provided by the primary care provider or by another provider through referral.*

To whom can PASSPORT providers refer?

Providers may refer a patient to any other provider who accepts Montana Medicaid. *If you refer to a provider who is not enrolled as a Montana Medicaid provider, the patient may be responsible for the provider's fee.*

What is an authorization?

An authorization is approval given by the PASSPORT primary care provider for services to be provided to a Medicaid client.

How is an authorization made?

Authorizations may be made either verbally or in writing.

The State encourages PASSPORT providers to make authorizations in writing. Written authorizations allow the patient and both providers to document that an authorization was made. The written authorization should be kept on file. Do not attach it to the claim.

Verbal authorizations must be documented in the patient's record.

What are the parameters of the authorization or referral?

The PASSPORT provider will establish the parameters, which may be for a one-time visit, a time specific period, or the duration of an illness or pregnancy.

Which PASSPORT services do not require authorization?

Some services do not require a PASSPORT provider's authorization because they are typically received only by referral, or, to require authorization might create a barrier to care or a public health risk.

Services which do not require authorization include:

- ambulance service for emergencies
- dental
- dialysis
- drugs (prescription)
- durable medical equipment
- emergency room
- eye exams
- eyeglasses
- family planning
- hearing aids
- hearing exams
- Home and Community Based Waiver
- home care/personal care attendant services

- home infusion therapy
- hospice
- ICF/MR/hospital swing beds (Intermediate Care Facility for the Mentally Retarded)
- immunizations
- mental health
- podiatry
- pregnancy-related services
- targeted case management
- transportation

What is an authorization number?

An authorization number is the number the PASSPORT provider must give to other providers when authorizing services. The authorization number can be:

- the PASSPORT provider's Medicaid provider number, or
- a specially issued PASSPORT provider number (7 digits beginning with 998 or 999), or

The authorization number must be on the claim form (unless you are the PASSPORT provider) or Medicaid will not pay for the service.

Authorization numbers are entered on the Medicaid claim forms in the following places:

- UB-92 Claim Form: Locator 11
- HCFA 1500 Claim Form: FIELD 17a

What happens if an authorization number is not used?

If a provider provides a non-emergency service without a PASSPORT authorization, and cannot get the number after the fact, the provider *cannot* bill the patient.

It is best to get an authorization number in advance, in writing, and specific to service(s) and date.

Where can a PASSPORT provider get an authorization number?

Consultec assigns an authorization number at the time the PASSPORT provider agreement is signed.

Reminders:

- A *provider's authorization number is often called a* PASSPORT *number.*
- A PASSPORT *provider can change his or her* PASSPORT *number by calling* 1-800-480-6823.
- *If a Medicaid client (whom the* PASSPORT *provider has not seen before) asks for a referral for services, the provider can refer if the services are medically necessary and appropriate. Remind the client to establish a patient-provider relationship with you or with another provider for future services.*
- *The* PASSPORT *provider's office must keep track of the* PASSPORT *number each month and make sure the correct number is given when authorizing services.*

- *When giving retroactive authorizations, it is important to use the correct number for the date of service being billed.*
- *Authorizations may be provided by the* PASSPORT *provider or a medical professional covering for him/her.* PASSPORT *authorizations may not be provided by office staff.*
- *Claims for* PASSPORT *services will be denied if authorization is not documented as described.*

Do not keep a copy of previously assigned PASSPORT *authorization numbers. If you do not receive authorization for a specific service, you cannot use a previously assigned number. To do so would be contrary to the provisions of the contract you signed with* DPHHS, *and may be subject to penalties.*

What is the role of Mountain Pacific Quality Health Foundation?

The Mountain Pacific Quality Health Foundation is under contract with DPHHS to preauthorize prescription drugs (1-800-395-7961), to operate the Medicaid Transportation Center (1-800-292-7114), to preauthorize mental health services, to review medical necessity decisions when necessary, and to provide quality assurance services.

For general information, call the Mountain Pacific Quality Health Foundation at 1-800-497-8232, Monday through Friday, 8 a.m. through 5 p.m.

Emergency Services

Is authorization required to use the emergency room?

No, as long as the condition presented is a *true* emergency. An *emergency* means that symptoms of the medical condition seem so severe that a prudent layperson (a person with average knowledge of health and medicine) would expect that there might be danger to the health of the individual unless the symptoms were treated immediately.

What if the client's condition is found not to be life-threatening or urgent?

If a Medicaid client presents at the emergency room with a condition that is not life-threatening or urgent and the PASSPORT provider does not authorize further treatment, Medicaid will reimburse the emergency room for the cost of the emergency assessment and stabilization service only.

The hospital staff should call the PASSPORT provider once the hospital has completed the COBRA* mandated assessment and stabilization and the condition is found not to be life-threatening or urgent.

The PASSPORT provider can authorize continued treatment in the emergency room or instruct the patient to seek care elsewhere.

Is post-stabilization authorization required?

In the case of an emergency, post-stabilization authorization by a PASSPORT provider will be sought by the E.R. staff. *If the* PASSPORT *provider cannot be reached within an hour, authorization will be assumed.*

MONTANA HEALTH CHOICES *analyzes the use of the emergency room by* PASSPORT *enrollees on a regular basis.*

PASSPORT *authorization does not replace or supercede existing limits on Medicaid benefits or Medicaid requirements for prior authorization for services.*

*(*Consolidated Omnibus Budget Reconciliation Act *— The act that allows people who work for a company with 20 or more employees to continue their health insurance temporarily should they leave the company.)*

Reimbursement and Billing

What amount are PASSPORT providers reimbursed for services?

Reimbursement for Medicaid services through PASSPORT is identical to Medicaid fee-for-service reimbursement. This allows providers the opportunity to become actively involved in cost containment and improvement of quality of care without financial risk.

How do PASSPORT providers make claims for services?

Claims are sent to Consultec, at PO Box 8000, Helena, MT 59604. See the yellow Medicaid manual for information about ordering claim forms and filing claims.

What if a claim for services is denied?

If you believe a claim has been improperly denied, you may contact Consultec at 1-800-624-3958.

Is the PASSPORT case management fee paid if the Medicaid client is not seen in a given month?

The $3 per month/per client case management fee is paid regardless of whether the patient is seen during the month.

Should providers bill Medicaid for case management fees?

No. PASSPORT providers do not bill for case management fees. Case management fees are paid monthly to each PASSPORT provider based on his or her assigned seven-digit authorization number.

Case management fees will be listed as procedure code z8150 for each PASSPORT enrollee on the provider's Remittance Advice (RA). The date of service for the code indicates the month for which the fee is being paid.

For example, the case management fee for a September 1999 enrollee will have a service date of 9-1-99.

Can a provider receive the case management fee as a separate check?

Yes. The provider must notify MONTANA HEALTH CHOICES at 1-800-480-6823 if he or she wants a separate check.

For more information on reimbursement of case management fees, see Section XI of the yellow Medicaid manual.

For questions about billing, contact Consultec at 1-800-624-3958.

Termination of PASSPORT Agreement

How does a provider terminate his or her agreement with PASSPORT TO HEALTH?

A PASSPORT provider's intent to terminate his or her agreement must be given to Montana Health Choices in writing at least 30 days before the date of termination. Termination notices should be sent to:

Montana Health Choices
PO Box 254
Helena, MT 59624-0254

Termination is effective on the first day of the month following notice of termination, or the first day of the second month following notice of termination, whichever allows a 30 day time period to elapse.

It is important to give notice of termination 30 days before the date of termination to ensure continuity of care and to allow clients time to choose another provider.

PASSPORT and Indian Health Services

All Native Americans are entitled to health services through Indian Health Services (IHS). Some Native Americans may also be eligible for Medicaid, and in those cases, Medicaid pays for services provided through IHS.

A Native American Medicaid client who receives services through PASSPORT TO HEALTH may choose IHS to be the primary care provider, as long as the IHS provider is a PASSPORT provider. The client may alternatively choose a PASSPORT provider other than IHS.

If the client chooses a PASSPORT provider other than IHS, he or she may go to IHS as well without a referral from the PASSPORT provider.

However, if IHS refers to another provider, the PASSPORT provider must first approve the IHS referral or Medicaid will not pay the bill.

All referrals by IHS *must be approved by the* PASSPORT *provider unless* IHS *is the* PASSPORT *provider.*

Client Enrollment

What is the client enrollment process for PASSPORT TO HEALTH?

Client enrollment in PASSPORT begins with the County Office of Human Services. After eligibility determination, the client is provided a packet of information about PASSPORT TO HEALTH, including a cover letter; *Getting Started with Your Medicaid Health Services* (a brochure that explains the enrollment process); *How To Choose* (a card that guides clients through the process of choosing a primary care provider); a list of available providers; and a postage-paid enrollment form. Clients may also enroll by phone, using the client HelpLine at 1-800-362-8312.

Which Medicaid clients are not eligible for PASSPORT?

Approximately 70% of Medicaid clients will be enrolled in PASSPORT TO HEALTH. About 30% are not required to enroll.

The following individuals may be exempt:

- those with both Medicare and Medicaid coverage;
- those who reside in a long-term care facility;
- spend-down clients who pay for a predetermined amount of their medical care monthly before they become eligible for Medicaid benefits;
- those on the Medicaid Restricted Card program;

- those residing in the Montana Developmental Center in Boulder, Eastmont Human Service Center in Glendive or Orchard View in Polson;
- those who live in a non-PASSPORT county such as Blaine or Sanders;
- those who get Medicaid for less than three months; and
- those who are temporarily eligible for Medicaid.

A client may request an exemption from PASSPORT TO HEALTH if he or she will not be able to access appropriate medical care if enrolled.

Clients who want an exemption from PASSPORT *should call* MONTANA HEALTH CHOICES *at 1-800-362-8312 to request an Exemption Form.*

How can a provider know if a Medicaid client is enrolled in PASSPORT TO HEALTH?

There are five ways to determine if a Medicaid client is enrolled in PASSPORT:

1. Check the Medicaid card. The words "PASSPORT PROVIDER" will appear on the Medicaid card under the client's name, along with the name and phone number of the PASSPORT provider. If you are not the provider listed on the card, you must receive authorization from the PASSPORT provider (unless authorization is not required) or your claim will be denied by Medicaid. (See the chart listing PASSPORT services requiring authorization on pages 10-18).

2. Check the TEAMS (The Economic and Assistance Management System) Public Access Screen. The Public Access Screen can be used to verify Medicaid eligibility and PASSPORT status, including the name and phone number of a client's PASSPORT provider, for any given month. There is a cost to subscribe to this service. Please refer to the yellow Medicaid manual, Section XI, for additional information.

3. Call the Medicaid Voice Response 24-hour Eligibility Verification Service at 1-800-714-0060. You can verify eligibility and PASSPORT status by using the client's Social Security number. The provider's phone number will not be given, however.

4. If you are enrolled in Fax Back call 1-800-714-0075 for written verification of eligibility. You can get the name and phone number of the PASSPORT provider through Fax Back.

To enroll in Fax Back, call Consultec at 1-800-624-3958.

5. Log on to MEPS (Medicaid Eligibility and Payment System). You can access client eligibility and claims status history through the Department of Public Health and Human Services' website. MEPS is available via the Medicaid kiosk in the DPHHS room of the Montana Virtual Human Services Pavilion: vhsp.dphhs.state.mt.us

   There is no charge, but you will be required to complete an access request prior to using the system. The MEPS security officer will contact you, verify information you have provided, and give you a MEPS password.

Information Available through Eligibility Verification Methods

	Medicaid Card	TEAMS/ Public Access	Medicaid Voice Response	Fax Back	MEPS
Eligibility	Yes	Yes	Yes	Yes	Yes
QMB eligibility	Yes	Yes	Yes	Yes	Yes
Incurment	No	Yes	Yes	Yes	No
PASSPORT	Yes	Yes	Yes	Yes	Yes
Restricted	Yes	Yes	Yes	Yes	Yes
Medicare A	Yes	Yes	Yes	Yes	Yes
Medicare B	Yes	Yes	Yes	Yes	Yes
Nursing home eligible	No	No	Yes	Yes	No
PASSPORT provider's name	Yes	Yes	No	Yes	Yes
PASSPORT provider's phone no.	Yes	Yes	No	Yes	Yes
Restricted primary MD	Yes	Yes	No	Yes	Yes
Restricted primary pharmacy	Yes	Yes	No	No	Yes
Copay	Yes	Yes	No	No	Yes
FULL or BASIC	Yes	Yes	Yes	Yes	Yes

Must each member of the family have the same PASSPORT provider?

No. Each person in the family may choose a different PASSPORT provider. For example, parents may choose a pediatrician for their child and an internist for themselves, or a family may choose to enroll all members with the family doctor.

What happens if a client fails to choose a provider?

Clients who do not choose a PASSPORT provider within 45 days after receiving the packet of information sent by MONTANA HEALTH CHOICES are automatically assigned a provider appropriate to the client's age, sex, and location. When possible, the assignment reflects the client's provider history.

Can clients change PASSPORT providers?

Clients may change PASSPORT providers by calling the toll-free client HelpLine at 1-800-362-8312 or by submitting a change of provider form. Clients can change PASSPORT providers every 90 days, or anytime, if they have sufficient cause to do so.

How do clients get information about the PASSPORT program?

MONTANA HEALTH CHOICES educates Medicaid clients in the following ways.

- MONTANA HEALTH CHOICES contacts clients new to PASSPORT to explain the program, answer questions, and take enrollment information over the phone.
- Each new client receives a *Client Handbook*. The Handbook explains the administrative procedures of the program and educates the client about primary care providers, the use of the emergency room, well child visits, pregnancy care, and the complaint and grievance process, among other things.
- A toll-free HelpLine is available to answer client's questions. The number is 1-800-362-8312. Clients may call Monday through Friday, 8 a.m. to 5 p.m.
- MONTANA HEALTH CHOICES provides educational materials for providers to distribute to clients.

Disenrollment of Clients

Can a provider disenroll a client?

Yes. A provider can ask to disenroll a client if:

- the provider-patient relationship is mutually unacceptable,
- the client fails to follow prescribed treatment,
- the client is abusive, or
- the client could be better treated by a different type of provider, and a referral process is not feasible.

What is the disenrollment process?

Providers should write a letter of intent to disenroll the client and send it to:

Montana Health Choices
PO Box 254
Helena, MT 59602

Providers must continue to provide PASSPORT management services to the client, either directly or through referral, while disenrollment is being completed. This process may take up to five weeks, depending on when the request is made.

The Complaint and Grievance Process

A complaint or grievance relating to any service covered under the PASSPORT program may be filed by a client or a provider.

What is a complaint?

A complaint is the report of a feeling that something wrong or not appropriate has taken place. That report is made verbally to the Provider HelpLine or the client HelpLine.

What is a grievance?

A grievance is a written complaint.

How should a provider file a complaint or grievance?

Call the Provider HelpLine at 1-800-480-6823, or write a letter and send it to:

MONTANA HEALTH CHOICES
PO Box 254
Helena, MT 59602

If the complaint is not resolved after calling the HelpLine or writing to MONTANA HEALTH CHOICES, you may ask for a fair hearing.

What is a fair hearing?

A fair hearing is a meeting between the provider, the client, and a fair hearing officer.

To ask for a fair hearing, call the MONTANA HEALTH CHOICES Provider HelpLine at 1-800-480-6823.

For complaints about alleged discrimination because of race, color, national origin, age or disability call the Office for Civil Rights at 303-844-2024 (TDD: 303-844-3439), *or write a letter to:*

Office for Civil Rights, U.S. Department of Public Health and Human Services
Federal Office Building
1961 Stout Street, Room 1426
Denver, CO 80294-3538

What happens when a provider or a client files a grievance?

The facts about the grievance are determined by asking questions of the complainant, by contacting the other party or parties as appropriate, and if warranted, by conducting on-site visits and interviews. All procedures are recorded.

A response is formulated based on a review of all facts. Responses may include, but are not limited to:

- clarification of PASSPORT policy to parties who have not acted in accordance with policy,
- advising clients how to change providers, and
- advising providers of procedures for disenrolling clients.

A written report is prepared and a response is sent to the complainant and other involved parties. The complainant is advised, in writing, about appeal rights through the Department. The final report is sent within 15 days of receipt of the complaint unless extra-ordinary circumstances dictate a longer time frame.

If you believe a claim has been improperly denied, you may contact Consultec at 1-800-624-3958.

Utilization Review

Are there utilization reviews in PASSPORT?

Yes. On a regular basis PASSPORT providers' utilization patterns will be analyzed. When a provider's average rates for service utilization are consistently high or low, the provider may be asked to furnish information regarding unusual practice patterns. Utilization reviews will be done by the Mountain Pacific Quality Health Foundation.

About PERC (Peer Education Review Committee)

PERC is a panel of Montana physicians that acts as a mechanism to provide education for fellow PASSPORT providers. PERC serves as a resource for PASSPORT providers who have questions about managing clients' health care services.

PERC is also a resource for deciding the best course of action when there is a need for physician intervention.

PERC works closely with DPHHS and MONTANA HEALTH CHOICES.

For more information about PERC, *call* MONTANA HEALTH CHOICES *at* 1-800-480-6823.

Tips for PASSPORT Providers

- ✔ Ask to see a client's Medicaid card at each and every visit.
- ✔ If services requiring authorization are provided *without* authorization, Medicaid will not pay for the services.
- ✔ When a woman is pregnant, there are no copayments for any Medicaid health services provided to her — even if the service is not related to her pregnancy. If you prescribe medication for a pregnant woman, be sure to tell the pharmacist that the prescription does not require a copayment.
- ✔ Before referring a PASSPORT client to another provider, check to see if the provider accepts Medicaid.
- ✔ Do not "piggy back" referrals. If a client is referred to you by a PASSPORT provider, you cannot refer him or her to someone else without the PASSPORT provider's authorization.
- ✔ If "provider pending" is on a client's Medicaid card, the card is a valid card, but the client has not yet chosen a PASSPORT provider. Encourage the client to choose a provider.
- ✔ If you see a Medicaid client frequently and that person has a PASSPORT provider, talk to the client about changing so that you can be the PASSPORT provider. Keep forms on hand for this purpose.
- ✔ Remember to provide 24-hour coverage for your PASSPORT clients, even when you are on vacation.

- ✔ For claims and eligibility information, use:
  - the Medicaid card;
  - the TEAMS Public Access Screen;
  - the Medicaid Voice Response 24-hour Eligibility Verification Service at 1-800-714-0060;
  - Fax Back at 1-800-714-0075; and
  - MEPS (Medicaid Eligibility and Payment System) at http://vhsp.dphhs.state.mt.us
- ✔ Promote well child visits, and encourage healthy living. (*Your monthly enrollee list shows who's due for a well child screen.*)
- ✔ Refer your patients to the client HelpLine at 1-800-362-8312 for health and program information.
- ✔ Let the PASSPORT program know if there are changes to your practice.

- ✔ Use the Montana Health Choices Provider HelpLine for questions about Medicaid.
- ✔ Make PASSPORT educational materials available in your office. Call the Montana Health Choices Provider HelpLine to request them.
- ✔ Read the Provider Newsletter for updates on the program.
- ✔ Contact Consultec for information on Medicaid claims.

Important Phone Numbers and Web Sites

Montana Health Choices/
PASSPORT HelpLine
for providers 1-800-480-6823

Call this number with questions about the PASSPORT program, Monday through Friday, 8 a.m to 5 p.m.

Montana Health Choices/
PASSPORT HelpLine
for clients 1-800-362-8312

Clients can call with questions about PASSPORT, Monday through Friday, 8 a.m to 5 p.m.

Citizen's Advocate Office 1-800-332-2272

Monday through Friday, 8 a.m. to 5 p.m.

Consultec 1-800-624-3958

Out of State 406-442-1837

Fax Back 1-800-714-0075

Medicaid Transportation
Center 1-800-292-7114

Monday through Friday, 8 a.m. to 5 p.m.

MEPS

See Web site: vhsp.dphhs.state.mt.us

Medicaid at the Department of Public Health and Human Services 406-444-4540

Monday through Friday, 8 a.m. to 5 p.m., or see web site: www.dphhs.state.mt.us/hpsd

Medicaid Voice Response 1-800-714-0060

Seven days a week, 24 hours a day.

Mountain Pacific Quality Health Foundation 1-800-497-8232

Monday through Friday, 8 a.m to 5 p.m.

Office for Civil Rights 303-844-2024

Monday through Friday, 8 a.m. to 4:30 p.m.

TDD 303-844-3439

Prior Authorization for Prescription Drugs 1-800-395-7961

Monday through Friday, 8 a.m. to 5 p.m. (for providers only)

State Coordinator for the Office for Civil Rights 406-444-3426

Monday through Friday, 8 a.m. to 5 p.m.

MONTANA HEALTH CHOICES

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